

**Deerfield Dentistry, LLC
Erik S. Atkinson, DDS
5530 Windward Parkway, Suite 410
Alpharetta, Georgia 30004
Phone: 770.360.5505
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Office Policy and Procedures
Effective 10/01/04

As a courtesy to our patients, we will be happy to complete and forward insurance forms relative to dental treatment, and we will do so without charge. However, in order to avoid misunderstandings, please read carefully and understand the following policies.

Our professional treatment is rendered to you, not the insurance company. You are responsible to us for the obligation of payment of treatment. Insurance is an agreement between you (the patient) and your insurance company and you are responsible for the balance regardless of your insurance.

However, to serve and assist you in utilizing your dental benefits, this office accepts assignment of your benefits. It is your responsibility to provide us with your insurance information and you are responsible for balances not covered by your policy on the day of service. If you have secondary insurance, we will provide all necessary forms for you – however, we will not file those claims.

Due to the increased cost of billing services, payment is expected the day of service for the first appointment, unless an alternate payment plan has been arranged. For extended treatment plans, we'll work with you to devise a method of payment beneficial to both of us. We accept major credit cards (Visa, MasterCard, and American Express), as well as CareCredit, a medical/dental credit card. We also accept personal checks, however your account will be charged \$50.00 for any returned checks. Any delinquent accounts that are turned over to a collections service will be charged a \$25.00 service fee.

As a courtesy to all our patients we ask that you arrive on time for your appointments as this time has been reserved just for you. After 15 minutes past your appointed time your reservation may be cancelled, or your treatment may not be completed at that visit.

We request a 2 business day notice prior to appointment if you have to reschedule. Those appointments with less notice are subject to an office visit charge of \$30.00.

If you are an adult patient being seen for an appointment we ask that you make child care arrangements for small children and infants if you bring the child with you.

State law requires a parent/guardian to be present during the entire appointment for children 17 and under.

I give permission for my dentist and his clinical team to take any necessary x-rays, photos, or study models to enable complete diagnosis and treatment.

Print Patient's Name _____

Patient/Guardian Signature _____ **Date** _____